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Rwanda Integrated Health Systems Strengthening Project:

Quarterly Project Report Narrative

(October – December, 2012)

CONTRACT N°: GHS-I-00-07-00006-00

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ACRONYMS

CBHI	Community Based Health Insurance (Mutuelle)
CHWs	Community Health Workers
CTAMS	Cellule Technique d'Appui aux Mutuelles de Sante (Mutuelle Technical Support Cell)
DG	Director General
DH	District Hospital (s)
DHIS-2	District Health Information System (New Rwanda HMIS System)
DQA	Data Quality Audit/Assesment
DRG	Diagnosis-Related Group
FMT	Financial Management Tool
HC	Health Center (s)
HMIS	Health Management Information System
HR	Human Resources
HSSP III	Health Systems Strategic Plan III
iHRIS	Human Resources Information System
IHSSP	Integrated Health Systems Strengthening Project
ISQua	International Society for Quality in Health Care
JCI	Joint Commission International (NGO)
JEMBI	JEMBI Health Systems (NGO)
MINECOFIN	Rwanda Ministry of Finance and Economic Planning
M&E	Monitoring & Evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NID	Rwanda National Identity Project
OPD	Out Patient Department
PBF	Performance-based Financing
PFM	Public Financial Management
PMI	President's Malaria Initiative

QI	Quality Improvement
RBC	Rwanda Biomedical Center
RMC	Rwanda Medical Council
SIS Com	Community Health Information System
SOPs	Standards Operating Procedures
SQL	Structured Query Language
IFMIS	Integrated Financial Management Information System
STTA	Short Term Technical Assistance
TA	Technical Assistance
ToT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

EXECUTIVE SUMMARY

In this reporting quarter (October – December, 2012), IHSSP/MSH made a number of achievements in strengthening health systems across all components.

Health Management Information System

Increasing capacity of policymakers: HMIS data collection and reporting manual was finalized and is under review for validation, a number of workshops where conducted on SQL queries and design of specialized reports using DHIS, district health teams and hospital administrators received training on strategic planning costing using a costing tool developed by IHSSP and the RBC M&E team received training on use of the DHIS-2 software platform.

Strengthened HMIS: IHSSP/HMIS team completed the importation of historical data from TracNet as well as key malaria indicators into the National Data Warehouse and completed the importation of new data from 14,000 village spreadsheets to update the income categories and household trees in the UBUDEHE database. The IHSSP/HMIS team finalized the selection of software for entering and analyzing data from the accreditation surveys and the first survey questionnaire for Provincial Hospitals has been imported into the system.

Health Financing

The IHSSP team supported the MOH in the preliminary steps to design a provider payment system (DRG) and its standard operating procedures and conducted an auto-evaluation workshop to strengthen and improve the use of CBHI Financial Management Tool (FMT) at the decentralized level.

The team also conducted trainings followed by mentoring of district pharmacies and CBHI structures on the Integrated Financial Management Information System (SMART-IFMIS) and provided technical support in elaboration of CBHI ministerial orders. Last, but not least, provided technical support to prepare and conduct the community health financing situational analysis that will help inform the community health strategic plan development.

Quality Improvement component

An accreditation steering committee has been established with clear roles and responsibilities. IHSSP/MSH supported the development of Rwanda hospital accreditation standards which has been finalized and disseminated to the health facilities. Also, IHSSP/MSH developed quality monitoring tools including assessment tool for surveyors and supervisors to guide the assessment

of hospitals, a standard job description of a surveyor and terms of reference for the recruitment of surveyors. The team was also able to disseminate Rwanda hospital accreditation standards, additional policies and procedures to 27 hospitals in 27 districts.

Cross-Cutting Technical Assistance

The ministry of Health made a number of ad-hoc requests to IHSSP/MSH to have some of the activities out of the IHSSP planned activities that were completed in this quarter. These include:

a) Finalizing the development of a decentralization strategic plan
b) Analysis of subsector policies and strategic plans for alignment with HSSP III
c) Review and update of the Health Sector Strategic Plan III document
d) Situation and functional analysis of Rwanda Biomedical Center (RBC)

INTRODUCTION

In November 2009, USAID launched the 5-year Integrated Health Systems Strengthening Project (IHSSP) focused on the 5 technical areas of: improving utilization of data for decision-making and policy formulation across all levels; strengthening health financing mechanisms and financial planning and management for sustainability; improving management, productivity and quality of human resources for health; improving quality of health services through implementation of standardized approach; and extended decentralized health and social services to the district level and below.

The main results expected to be achieved by the Project are:

- Improved capacity of the program managers to use data for decision making
- Strengthened HMIS to provide timely data
- Strengthened financial systems for the rational use of available health resources
- Strengthened MOH capacity for cost reduction, revenue generation, and cost-sharing for services
- Increased MOH technical capacity, especially in economics and financial management
- Implemented and evaluated long-term HRH strategic plan and Community Health Worker (CHW) policy
- Improved capacity of MOH to use HRMIS to update and disseminate HR norms and guidelines
- Improved and strengthened MOH capacity to manage human resources for health (HRH)
- National supervision framework implemented, strengthening linkages between and within MOH and district health and management teams
- District management teams implement QI mechanisms including regular supervision of health facilities and providers, performance-based contracts, and on-site mentoring at health centers to ensure implementation of QI projects
- Management capacity at decentralized levels improved and extended to all levels, including local communities
- Strengthened capacity of local CSOs and individual community members to influence health sector priorities and services.

The present report describes the activities and main achievements realized by the Project during the reporting quarter (October to December 2012).

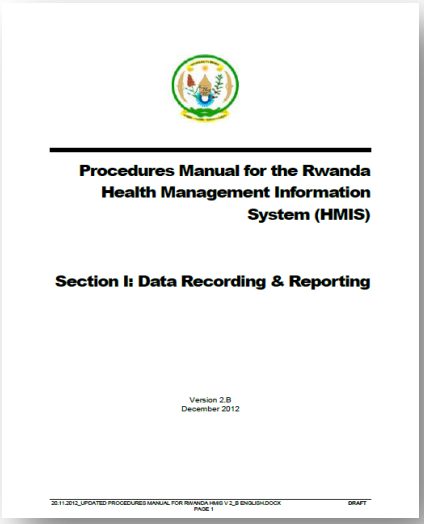
I. IMPROVED UTILIZATION OF DATA FOR DECISION MAKING AND POLICY FORMULATION

1.1. Increase capacity of policymakers to collate, analyze, use and disseminate information:

- **Finalization of the first draft of HMIS data collection and reporting manual**

This manual was completed and distributed to MOH reviewers for validation in December 2012 and should help improve data quality once it is broadly disseminated to data managers across the country. IHSSP/HMIS team also worked with WHO and MOH to develop a work plan and budget to enhance the quality of analysis of data in the MOH annual report and the implementation of the National and District health profiles as part of a national health observatory.

Figure 1: HMIS data collection and reporting manual



- **Enhancement of data sharing**

With the approval of the data sharing policy, IHSSP worked with the MOH/HMIS unit to develop a system to track data access requests and provided an initial series of orientations to the DHIS-2 dashboard for staff from USG and other partners.

- **Capacity building:** In this quarter, the IHSSP/HMIS team built the capacity of HMIS teams from the central and the district level including decision makers on data use and management through trainings and workshops as follows;
  - **MOH/HMIS team:** IHSSP focused on technical training in the design of Structured Query Language (SQL) queries and specialized reports using DHIS-2. This training was conducted through the short term technical assistance (STTA) from HISP/East Africa. The Ministry has also requested support for a workshop on M&E concepts and the development of standard operating procedures for data management across the central level MOH/RBC departments.

- **District Hospital and Administrative district health teams:** IHSSP funded two workshops organized in Musanze and Huye by the MOH/Planning unit to train district health teams and hospital administrators in the use of the strategic plan costing tool; the tool was also adapted by IHSSP and CHAI staff for their own planning purposes. Nearly **150** people were trained during the 2 day sessions.
- **RBC Monitoring & Evaluation team:** At the request of RBC M&E coordinator, the IHSSP/HMIS team organized a 3 day training sessions on use of the DHIS-2 software platform for the RBC team. During the training, the RBC team was able to create the monthly reporting system for OVC support – previously collected on spreadsheets and aggregated by the districts.

1.2. Strengthened HMIS to provide reliable and timely data

- **Implementing new functionality on the DHIS-2 platform**

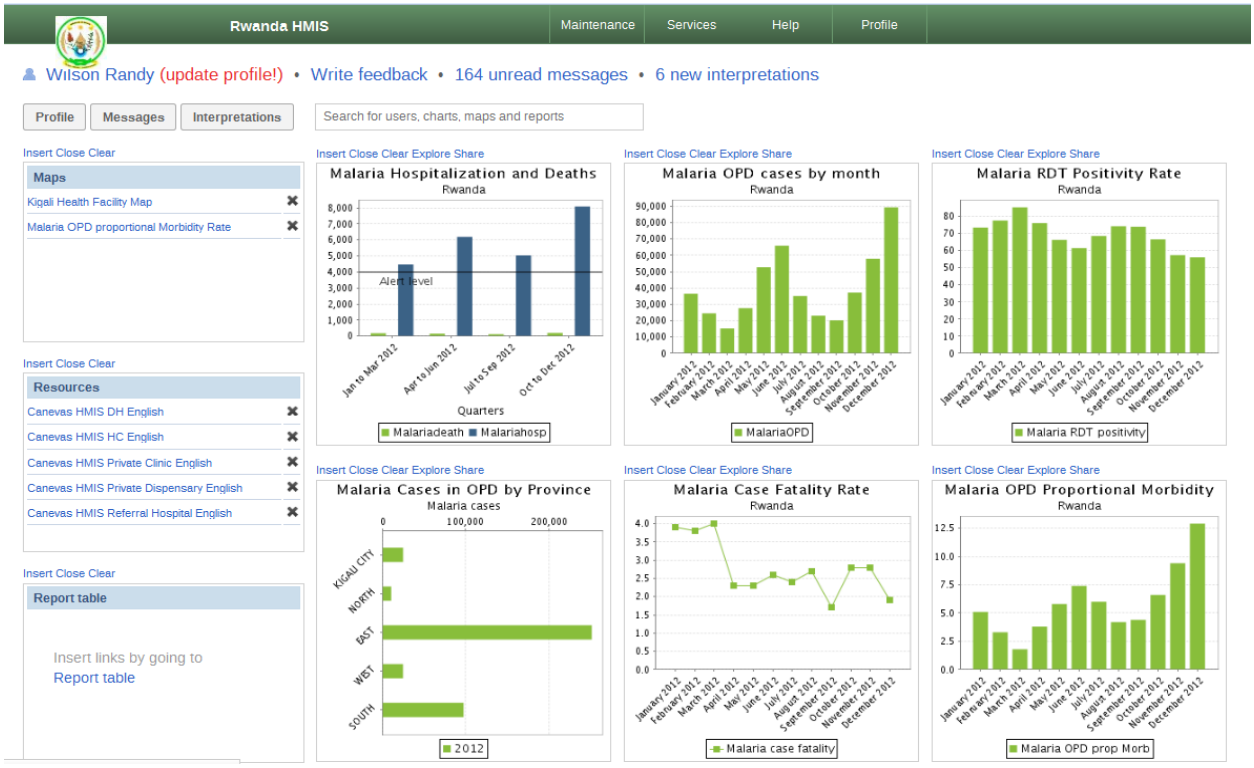
IHSSP continued to support the implementation of the new functionality on the DHIS-2 platform. This included reconfiguring the organizational unit hierarchy to display health facilities by administrative sector, collecting remaining GPS coordinates for Health Centers, Hospitals and VCT centers, and adding new modules for TB quarterly reporting and death audit reporting.

The migration of the SIScom community health worker reporting system to the DHIS-2 platform was completed, creating custom queries and reports for preparing PBF payments and comparing performance against targets. IHSSP also helped the MOH/HMIS team to develop a module for entering the routine data quality audits (DQA) that are done every 6 months throughout the country. This will help to quantify progress made on the data quality issues.

- **Set up and use of dashboard and data warehouse**

With technical support from IHSSP, the importation of historical data from TracNet as well as key Malaria indicators was completed. Following the approval of the data sharing agreement, the IHSSP/HMIS team also gave general orientation on the data warehouse and other DHIS instances to USG staff, PMI team members, the new DG for Planning in the MOH, and the M&E & HMIS teams.

Figure 2: Malaria Dashboard in Rwanda DHIS-2



In addition to providing regular analyses of Malaria data from the HMIS and SIScom, the National Malaria Control Program has requested IHSSP to help sort out a phone-based reporting system initially developed with Tulane University support. This began in the past quarter through the meeting with the Tulane team and the development of a concept note specifying current issues and possible options to operationalize the system.

1.3. HMIS Cross-cutting Technical support:

- **Support to the Human Resource Information System (iHRIS):**

The IHSSP/HMIS team continued to provide basic support for the human resources information system, helping to mentor district Human Resource staff through the data entry processes. In the next quarter, there will be the beginning of the transition of the professional council licensing database, which was originally designed in MS-Access and will be translated to the web-based iHRIS Qualify platform for easy use.

- **UBUDEHE population income categorization database:**

IHSSP/HMIS staff completed importing the new spreadsheets from 14,000 village spreadsheets to update the income categories and household trees; this is no longer seen as health sector task. The recommendation made is that the database should be integrated with the national identity card (NID) project and the civil registration systems under MINALOC's leadership.

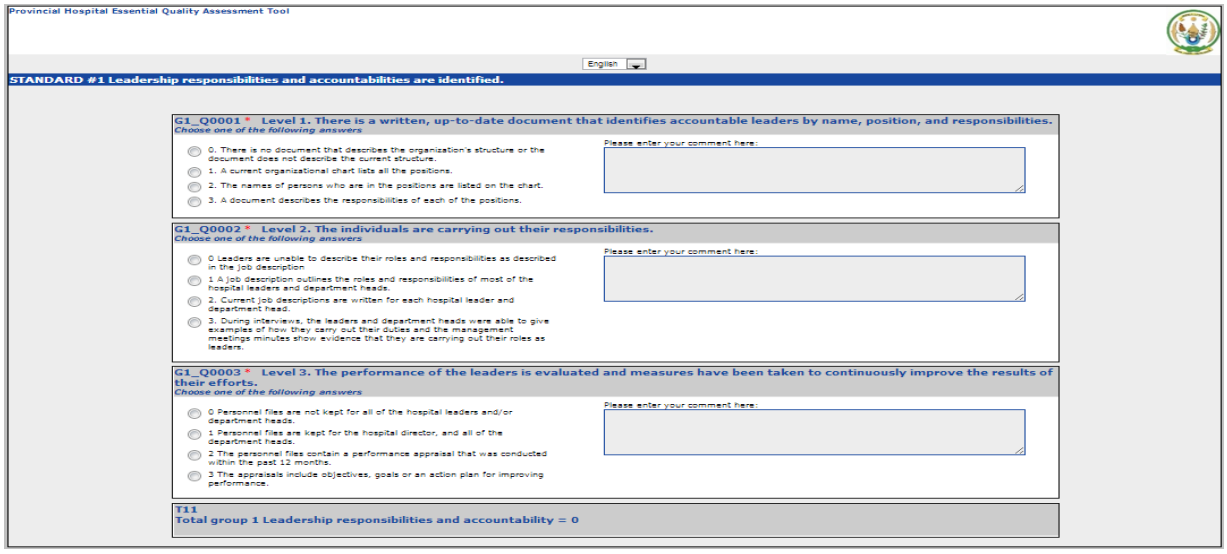
- **Enhancement of Mutuelle/CBHI membership and M&E databases:**

These activities were scheduled to be implemented later in the year, but began this quarter due to the enthusiasm over the district CBHI financial management tool introduced by the health financing team at that time. The MOH has signed a contract with JEMBI health systems to develop the web and mobile phone based membership system. The e-Health coordinator has appointed two IHSSP/HMIS staff to oversee the technical steering committee. This system will include a mobile banking option to enable Rwandans to pay their mutuelle memberships by cell phone.

- **Support for Accreditation process:**

The IHSSP/HMIS team has evaluated a variety of software options for entering and analyzing the data from the accreditation surveys. An open source system, Lime-survey, has been selected and the first survey questionnaire for Provincial Hospitals' assessment has been imported into the system. This should enable the accreditation team to analyze accreditation results over time and to produce special reports highlighting specific gaps in each facility.

Figure 3: Lime-survey tool for accreditation program



- **Technical assistance to the MOH/M&E unit in support of HSSP III:**

IHSSP/HMIS provided technical support in 3 areas towards finalizing the Health Sector Strategic Plan III:

- In support of consultants, IHSSP/HMIS staff provided support to the consultants on the analysis of the alignment of subsector policies and strategic plans with the new HSSP III
- Planning and resource mobilization for the implementation of national and district health profiles on a public web portal – mostly funded by WHO as part of their national health observatory initiative.
- Copy editing and desktop publishing of the final version of HSSP III

- **Participation in the international conference on Impact Evaluation of PBF, Istanbul/Turkey**

IHSSP/HMIS advisor facilitated a conference session on integration of PBF systems with HMIS, building on the experience with Rwanda's Community PBF system which took place in this quarter in Turkey.

- **PMI program support**

In addition to providing regular analyses of malaria data from the HMIS and SIScom, the National Malaria Control Program has requested IHSSP to help sort out a phone-based reporting

system initially developed with Tulane University support. This began in the past quarter through the meeting with the Tulane team and the development of a concept note specifying current issues and possible options to operationalize the system.

1.4. Challenges/Constraints, Lessons Learned and Next steps:

Challenges/Constraints

- **Lack of counterpart at MOH HMIS unit:** The National HMIS coordinator has been absent for 4 months and it is still unclear about time frame for replacement. IHSSP/HMIS advisor has to represent the HMIS unit at a variety of meetings that should be covered by MOH staff; this limits the involvement of the MOH/HMIS unit, where for example it has no representation in the MOH senior management meetings.
- **Limited capacity within MINALOC to manage the Ubudehe income categorization database:** IHSSP has been asked to move this Ubudehe application over to MINILOC, but they current have no data center or internal ICT capacity to support the system. The MOH needs these data to be maintained regularly in order to correctly manage mutuelle/CBHI members yet the database is 'owned' by MINALOC.
- **Slow progress on the finalization of HMIS recording and reporting manual:** IHSSP subcontractor, Futures Group, has not been able to secure the level of engagement required – particularly from RBC/HIV staff – to harmonize and document existing recording and reporting instruments. These are crucial for improving the quality of data collected.

Lessons Learned:

- **Operationalization of the DHIS-2:** The first year of operation of the DHIS-2 platform has proved to be successful beyond our expectations. A wide variety of other data collection and dissemination systems have begun to piggy-back onto the system because it is so easy to configure and there is now a critical mass of data management staff across the country who have been trained to use it.
- **The use of strategic plan costing tool:** The strategic plan costing tool that IHSSP staff developed has proved popular with a variety of audiences – including eHealth, the Administrative District Health teams, and the District hospitals – for costing their strategic

plans. Rwanda's UN agencies have even adopted it for costing their new one UN strategic plans. Following the strategic plan alignment exercise which identified costing as a major gap in many strategic plans, the Ministry might want to propose this a standard activity-based costing tool.

Next steps and plans for next quarter:

- Focus on building internal data validation rules for key tables from the RHMIS to further improve data quality.
- Complete changes to CBHI periodic reporting systems and web-based CBHI financial management tool
- Complete migration of nursing and medical council licensing and registration systems to iHRIS.
- Test Lime-Survey-based Accreditation Survey tool and train QI team to maintain it
- Continue the oversight of CBHI membership database implementation
- Respond to the request of the ministry to provide practical M&E training for central and district level M&E staff and senior managers. Use this opportunity to develop a data management SOP describing clear roles and responsibilities for data management for central level M&E staff working in RBC and other MOH divisions. Adapt the curriculum to help orient administrative district M&E officers in M&E fundamentals.
- Complete phase 1 of the National Health data warehouse, moving in historical data from the GESIS (pre 2012 HMIS system), integrating key indicators from HSSP III and cleaning up the metadata dictionary.
- Finalize the health facility registry and develop the interoperability profile with the DHIS-2.
- Assist the Ministry with the preparation of the 2012 Annual Health Statistics Booklet and other periodic analyses.
- Work with the Ministry and WHO to begin the implementation of the national health observatory (web portal for national and district health profiles).
- Continue to assist RBC and MOH units to migrate their data collection systems to the DHIS-2 platform.

- Support the move of most of the MOH web servers to the National Data Center and re-configuration of a smaller data center.
- Organize capacity building around MOH web-site maintenance and content development
- IHSSP/HMIS team will help to sort out a phone-based reporting system developed by Tulane University as requested by the national malaria control program.

II. STRENGTHENED FINANCIAL SYSTEMS FOR THE RATIONAL USE OF AVAILABLE HEALTH RESOURCES

2.1. Design of provider payment systems (DRG) and their standards operating procedures

➢ **Road map for DRG implementation in Rwanda**

The Rwanda Ministry of Health with the support of the IHSSP convened a 2-day workshop on Provider Payment Mechanism Reform, with a focus on mechanisms based on Diagnostic Related Groups (DRGs). The workshop took place on the 18th through the 19th of October.

The primary goal of this workshop was to explore different options available, including DRGs, and to ultimately establish a work-plan to guide the process. The specific objectives of the workshop were:

1) To gain an understanding of provider payment mechanisms and underlying incentives and risks
2) To explore models in similar country contexts
3) To assess the current capacity and potential barriers
4) To outline potential steps or needed inputs to move towards the potential implementation of DRGs or case-based payment system

The workshop covered the components of a DRG system and the sub-systems that must be in place for successful implementation. It also briefly described actions taken to date and potential synergies. The reasons why Rwanda is moving towards a DRG-based provider reimbursement system and the policy objectives that Rwanda hopes to achieve were outlined. The session also briefly outlined the potential benefits of DRG systems and some challenges that Rwanda may face as it moves in this direction. An assessment of programs that are already in place that could

possibly support the rapid implementation of the DRG system in synergistic ways was conducted, and some specific policy issues were highlighted with recommendations to the MoH. From the workshop, a number of recommendations were outlined as follow:

- The policy objectives must be stated precisely. This information will help to determine the baseline against which progress will be measured, and determine which indicators should be used to measure the system performance;
- Some degree of autonomy should be given to hospital management (e.g. cost determination)
- Examine whether multiple provider payment and billing systems will increase the workload for staff, thereby defeating the purpose of having a simplified payment system;
- Implement DRG systems slowly and simply. The workshop suggested a stepwise, cautious approach starting with simulating implementation and looking at possible negative effects or areas which need additional design work;
- The MoH should institute measures to raise quality standards through various methods such as PBF and accreditation;
- The MoH should conduct an assessment of diagnostic and coding capability and where necessary institute training programs to improve provider performance;
- The DRG system should be applied initially only to hospital inpatient acute care services and one case (DRG) reimbursement rate applied to all the health centers and the hospitals OPD diagnoses.

IHSSP in collaboration with interested partners will continue to support the MOH by providing technical assistance on how to introduce and implement DRGs and broader changes to the reimbursement system. These changes are aimed at making the billing system easier to administer from both the provider and insurer viewpoints, transferring some of the financial risk from the insurer to the hospital or clinic, and making it easier to predict the total claim expenditures.

2.2. Support MoH in the implementation of national and decentralized CBHI financial management tool (FMT)

- **CBHI Auto Evaluation**

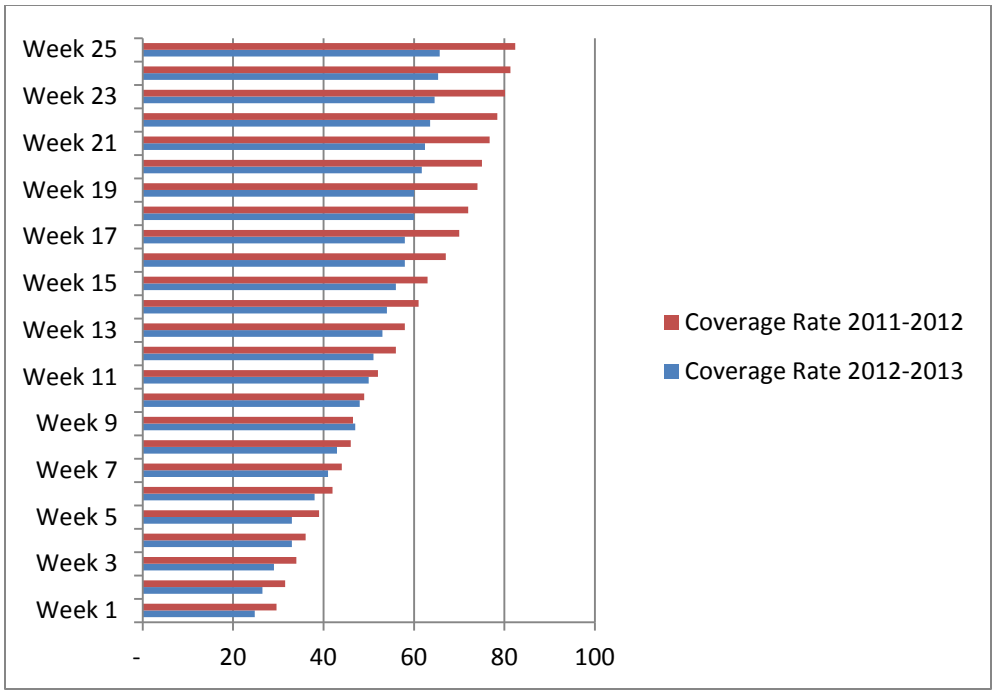
During the week of November 11th to 17th, 2012, the MoH/HF in partnership with IHSSP organized a quarterly meeting with the district directors. The overall objective of this auto evaluation was to strengthen the financial management of the CBHI at the decentralized level. The participants in this auto evaluation workshop included the Director of Health Financing Unit at the MoH; the National Pooling Risk Coordinator; the MoH-HF-CBHI-Data Manager; the MoH-HF-PBF Coordinator; MoH-HF-CBHI Supervisors; District Executive Secretaries; and MINCOFIN representatives.

The main topics discussed during the CBHI auto evaluation were: (i) the situation about the population enrollment within the CBHI for the second year of the new policy; (ii) auto-evaluation of the CBHI districts financial analysis under the new policy; (iii) new directives from MINECOFIN on the CBHI funds management; (iv) refresher training on the Financial Modeling Tool; (v) other challenges met by CBHI district office.

(i) CBHI Coverage rate

When comparing the CBHI enrollment rate for the year 2012/2013 and 2011/2012, the enrollment rate of the year 2012/2013 is found to be lower. This can be seen on the below figure comparing the 2 years national coverage rate week by week.

Figure 4: CBHI enrollment rate for the year 2012/2013 and 2011/2012



Among the causes for this low CBHI coverage rate is the delay in disseminating the socio-economic (UBUDEHE) data which allows the population to know their CBHI category and thus the amount of their contribution. A further assessment is needed to explore other reasons of this low coverage.

(ii) CBHI Financial analysis (Quarter 1, 2012-2013)

During the auto evaluation workshop, each district CBHI Director presented the situation of his district using the Financial Modeling Tool. The Financial Modeling Tool allows the collection of key indicators of the CBHI (i.e. enrollment, health services utilization by CBHI members per section & per district, revenue, and expenses). While analyzing the financial situation of the sections, the general finding is that the revenues are still low due to the low CBHI coverage rate.

On the expenses side, it was found that the operating costs are very high compared with the projected ceiling of 5% of the premiums which should be used for running costs. The district Directors were asked to work on this issue together with the district CBHI Boards.

(iii) MINECOFIN instructions on the Management of the CBHI funds

On the 3rd day of the conference, MINECOFIN representatives presented new instructions on the CBHI public financial management".

The instruction on the management of the CBHI funds was put in place by MINECOFIN based on the law n° 37/2006 of the 12th Sept. 2006 on the management of the Government fund.

The discussion with MINECOFIN was concluded with 2 possible scenarios:

1. All the contribution (100%) should be transferred to the District Common Account/Deposit Account opened in the BNR (before the reallocation to the section levels)
2. The section will continue collecting the membership contribution and 55% will remain at the section level and the remaining amount will be transferred to the District Common Account.

One of these scenarios will be selected after a meeting between MINECOFIN and the MoH. The Districts will be informed through an official letter.

(iv) Refresher Training on the Financial Modeling Tool

On the agenda of the auto Evaluation workshop was the refresher training on the Financial Modeling Tool.

The main focus of this training was the projection function of the tool. All the districts using their data for 3 months (the auto evaluated quarter) were able to do a guided exercise on projection of different indicators for the remaining period of the year and learn how to make analysis on projected data compared with actual data.

The figure below shows a kind of the analysis done (auto generated report from the Financial Modeling Tool for Kayonza District).

Figure 5: Financial Modeling tool: Section data analysis for Kayonza District

CBHI FINANCIAL MODELING TOOL : SECTION ANALYSIS - SUMMARY

Data Entry from July / Juillet 2012 to September / Septembre 2012

District: KAYONZA

User Guide | Data Entry - Sections | Ident | Data En

	Cyarubare			
	Actual Data (3 months) July / Juillet 2012 to September / Septembre 2012	Expected Data - Actual Period (3 months) July / Juillet 2012 to September / Septembre 2012	Projected Data - Remaining Period (9 months) September / Septembre 2012 to June / Juin 2013	Full year Projection July / Juillet 2012 to June / Juin 2013
1. CBHI Enrollment				
Enrolled Population: Category 1	-	4,638	2,183	6,821
Enrolled Population: Category 2	10,744	12,014	5,653	17,667
Enrolled Population: Category 3	-	35	16	51
Total CBHI Enrollment	10,744	16,687	7,852	24,539
% of Total Population Enrolled CBHI	41%	63%	30%	93%
2. Utilization - CBHI Members				
Total Consultations Externes / Outpatient Visits	3,477	1,571	6,139	7,711
Consultations Externes per Capita (CBHI)	0.32	0.09	0.78	0.31
Total Hospitalizations / Inpatient Stays	132	58	225	283
Hospitalizations per Capita (CBHI)	0.01	0.00	0.03	0.01
3. Revenue				
Premium Contributions: Category 1	-	5,102,108	2,400,992	7,503,100
Premium Contributions: Category 2	32,231,300	36,040,680	16,960,320	53,001,000
Premium Contributions: Category 3	-	242,760	114,240	357,000
Total Premium Contributions	32,231,300	41,385,548	19,475,552	60,861,100
Co-Payments	500,800	235,263	919,111	1,154,375
Sale of Tools and all other Revenue	900	900	2,700	3,600

The result from this exercise showed that the coverage rate is below the expected one at the end of the first quarter. It allowed making recommendations for all the sections on many other aspects (Revenue collection, expenses monitoring, etc).

(v) Other challenges

Another main topic discussed during this workshop was the data quality issue. While analyzing the reported data, some results showed that the collected data were not reliable. The recommendation was to conceive a system of regular data audit.

2.3. Training and mentoring of decentralized levels on PFM

- **Capacity transfer to district pharmacies and CBHI structures on the Integrated Financial Management Information System (SMART-IFMIS)**

A Ministerial order for the management of CBHI funds and district pharmacies was developed and disseminated by the Ministry of Finance on October 11, 2012. The objective of this Ministerial instruction is to include the CBHI financial operations in the district financial system (SMART-IFMS) in order to ensure the public financial management by health structures.

The goal of this training was to ensure better implementation of the MINECOFIN instructions and the use of the Smart-IFMIS. The workshop took place from November 20th to November 22nd for CBHI actors and covered: *chart of Accounts (day1), online data entry in the general ledger (day 2)* and r*eporting system with Smart-IFMS (day 3)*.

The MSH/Health Financing Unit made a visit to MINECOFIN on April 23 to understand how *Smart-IFMS* works. The team proceeded to have the experience of how the system works at Nyarugenge District and identified advantages and disadvantages associated with the system. During the visit the team learned that MINECOFIN is not ready to include the health facilities and CBHI in SMARTFMS at the moment due to the issues of management, backup and connectivity.

a. Lesson learned /Advantages of the IFMIS

- The system is an international Standard with big economic aggregates to report the country financial statement
- The system is web-based with the advantage of having daily financial statement
- The system captures all district revenues and expenses (collection from taxes and expenses for the district operating costs).
- With a web-based system, there is a possibility to secure the backup at the MINECOFIN servers
- The reporting system produces the balance sheet and the income statement automatically.
- The report on transaction is produced on PDF format with the possibility to print and have signature for approval.

b. Challenges /Disadvantages of the IFMIS

- The Chart of Account does not reflect the CBHI activities and is not specific for the CBHI reporting system
- The system is based on the budget logic and process (make planning first, make the budget approved and use the money planned for the activities, budget revision etc.). With this logic, there is no reserve or remaining money. The unused funds are relocated. The

CBHI has already a reserve policy for equalization and sustainability that has to be considered.

- The system is based on tender for reimbursements. The medical process does not respect tender system (between provider and Mutuelle). Most of the CBHI funds are for services reimbursement and follow the mechanism of verification.
- The system uses the accounting classifications that reflect only different levels of health facilities. It does not have a classification that corresponds to the CBHI activities.
- There is limited knowledge about the functionality and CBHI revenues at MINCOFIN level. No evident data available and no research done to confirm that 55% of the Mutuelle funds come from the membership contributions (not from the budget allocation or fiscal principal of the GoR)
- The reporting system does not permit analysis (especially utilization which is the objective of the CBHI, etc.). The reporting system is limited to the balance sheet and the income statement.
- The system does not reinforce the ownership by communities.

c. Way forward for dialogue and common understanding between MoH and MINECOFIN

- MINECOFIN and MOH will continue the dialogue on the financial management of CBHI and the district pharmacies; they consider that those use public funds and therefore must establish principles, policies and mechanisms for the management.
- Increase literacy of MINECOFIN on CBHI principles.
- Harmonize and optimize the chart of accounts for CBHI and Reporting System to avoid duplication.
- There is a need to understand that the medical reimbursement does not require a tender process or provider selection.
- The system (Smart-IFMIS) is more efficient at District and not at the section level. With the system of money transfers (bank to bank), the sections will lose a lot of money that can save lives.

- The CBHI District can open an account at BNR (separate from the Admin District account) to avoid the use of the CBHI money by the District.
- For the CBHI reporting system, make sure we have two bank accounts at the district: staff management and hospital reimbursement.

2.4. Increase capacity of policy makers related to CBHI and PBF Management

➢ **CBHI Ministerial Orders**

During the Month of November, IHSSP was called to provide technical support to the MOH team to elaborate the CBHI ministerial orders.

The main content of the Ministerial orders was about the agreements that will be signed between the CBHI Scheme and the health facilities at all levels (i.e. from the health centers to the referral hospitals).

Those agreements give directives for different aspects like the access to care by CBHI members, the invoicing process by health facilities, and the payment process by CBHI scheme. They show the obligations of each actor. The Ministerial Orders have been submitted to the Minister's office for review and signature.

2.5. Conduct audit of the community PBF system and functional assessment of CHW cooperatives with PBF payment mechanism

➢ **Community PBF counters verification and system audit**

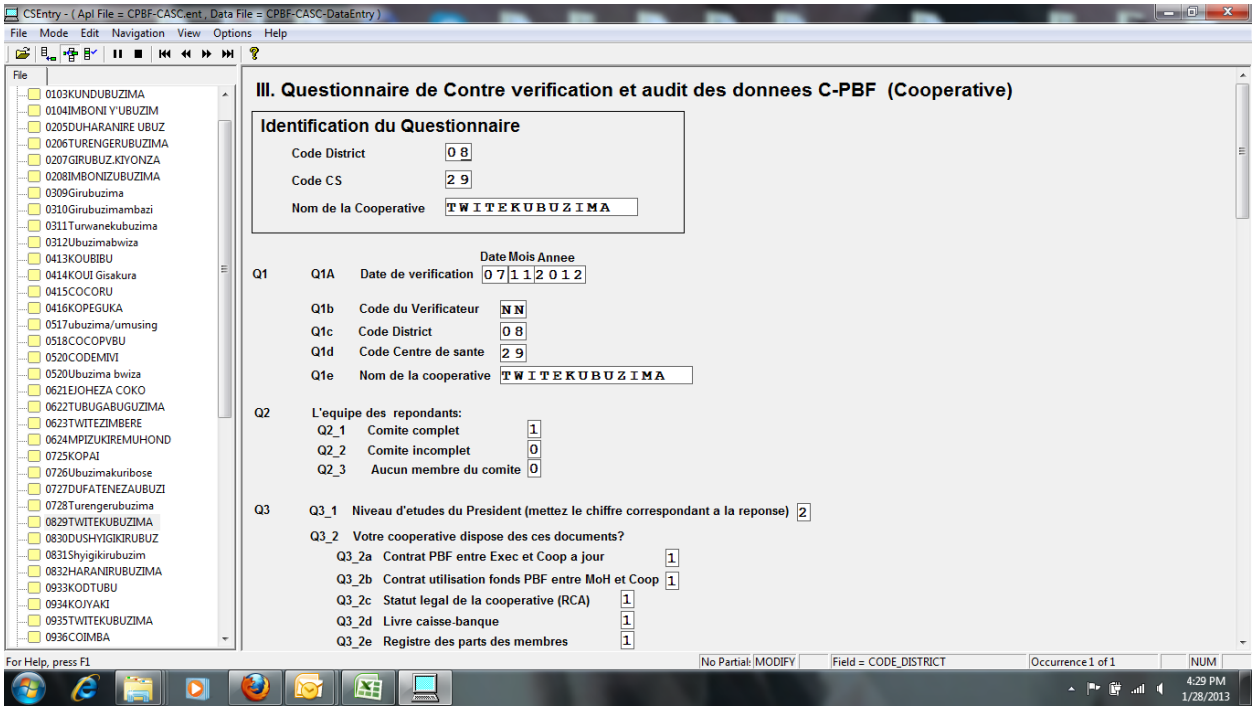
IHSSP supported the MoH/ Community health desk to conduct the second community PBF (CPBF) system audit and counter verification exercise. The CPBF approach is aimed at accelerating health results by focusing on high impact community level health interventions. In 2008, an improved form of community PBF was started where CHW cooperatives were compensated based on performance on a pre-determined maternal and child health indicators. The payments to the CHW cooperatives are made when the agreed level of performance has been reached. It is recommended to perform regularly a counter verification process by an independent unit for the following aspects of the PBF-model:

1. Accuracy of quantity as reported in the central PBF database

2. Verification of existence of phantom patients and of existence of service rendered
3. Client satisfaction
4. Audit of the community PBF-system and procedures

The objectives of these exercises were two-fold: 1) assess whether the community PBF-framework was implemented as designed and 2) establish a system of audit and data verification. The survey was conducted nation-wide in 15 randomly chosen districts, from which 53 CHW cooperatives, 60 health centers, 180 CHWs and 15 district hospitals were randomly chosen, and where in total 240 clients of community activities were visited. Within this activity IHSSP provided technical assistance, through the development of audit's questionnaires, development of data entry mask (using CSPRO), data consolidation and cleaning, and analysis.

Figure 6: PBF counter evaluation and system Audit - Data entry mask for CHWs Cooperatives questionnaire



Main findings from the Community PBF counter evaluation and system Audit

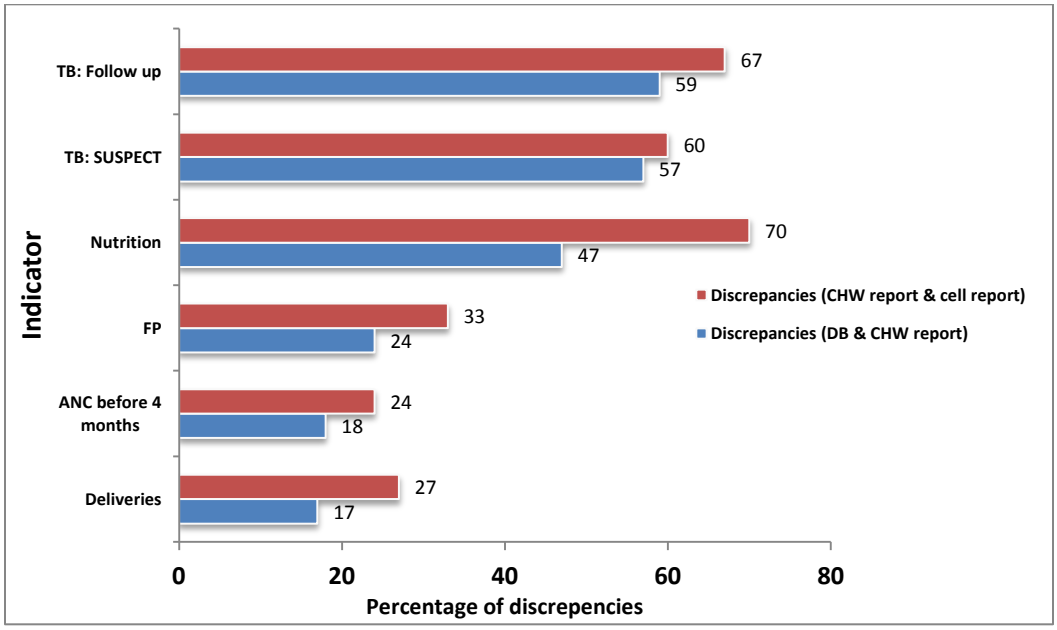
***i) Governance and institutional framework of CPBF*:** The CPBF contracts translated into local language Kinyarwanda, which are physically available and updated in 83.3% of cases, have facilitated a better understanding of community health workers in performing their tasks as well as members of sectors steering committee. Sector steering committee meetings are held regularly and this is shown through the availability of meeting minutes at the health center level (in 93.3% of visited structures). Local NGOs supporting community activities exist but need more technical expertise to support health centers and CHW cooperatives.

ii) Community PBF funding: an improvement in the regularity and the process of CHW cooperatives' payment is noted. For the fiscal year 2011-2012, a total amount of 4,972,592,474 Rwandan francs (US $ 8,287,654) was transferred for the remuneration of CHW cooperatives. Community TB indicators are contributing to 13.7% of the total funding of cooperatives. The total cooperatives funding still seems insufficient to ensure proper functioning and their ability to engage in income generating activities to increase their motivation. The majority of cooperatives have not yet arrived at the stage of making profits to be shared. The current average capital of cooperatives is almost 23,305,304 Rwandese francs. Cooperative investment is made in a number of income generating activities especially in the field of trade.

iii) Data management and community PBF indicators: Major discrepancies are noted in data reported when comparing the monthly reports from CHW reports with reports at cell level and reprts compiled at the health center level database.

The graph below displays the results for the discrepancies of CHW data for remunerated indicators between the CHW report, cell report (in red) and between the CHW report and the health center data base (in blue).

Figure 7: Results for the discrepancies of CHW data



2.6. Support the development of health financing strategic plan

- **Community health financing situation analysis**

IHSSP continued its involvement in the community health financing situational analysis through the assessment of the current status of the community health financing interventions and identification of achievements and challenges related. The situation analysis report will serve as input into the strategic planning process and will be the reference document for the development of the community health strategic plan.

2.7. Next steps/Plan for HF activities

- Continue to support MoH in the implementation of national and decentralized CBHI Financial Management Tool (FMT)
- Develop and introduce web interface for the CBHI Financial Management Tool
- Support the CBHI and PBF Extended Team coordination mechanism and editorial committee for capacity transfer
- Develop equity policy for the PBF budget allocation to health facilities
- Support the development of the health financing strategic plan.

- Develop SoPs for CBHI data management and audit
- Provide possible software for PBF/Accreditation checklists
- Continue to discuss on the provider payment systems (DRG) and their standard operating procedures with MOH.
- Conduct a study on analysis of the access, equity and efficiency of CBHI system
- Conduct an analysis on financial sustainability of both facility based and community health PBF
- Develop lessons learned document on CBHI and document best practices on CBHI Rwanda
- Develop and harmonize the CBHI M&E indicators and the financial management tool
- Develop technical specifications for accounting software for health facilities

III. QUALITY IMPROVEMENT FOR RESULTS IN ACCESS TO AND QUALITY OF SERVICES THROUGH STANDARDIZED APPROACH

3.1. Establishment of accreditation system

In September 2012, the Ministry of Health (MOH) launched an accreditation program as a priority intervention for improving quality and safety within healthcare facilities. USAID supports this priority intervention through IHSSP to establish the system and start an accreditation program in five provincial hospitals and two referral hospitals, which can later be rolled-out nationally to all district hospitals.

Most of healthcare accreditation activities started within this quarter including the establishment of an accreditation steering committee with clear roles and responsibilities to design the Rwanda accreditation system model, adapt JCI essential standards to the Rwandan setting and to develop an accreditation strategy that will provide direction to the national accreditation program. The accreditation model, the strategy and the regulations will be finalized in the next quarter.

The accreditation steering committee also developed the guiding principles of the accreditation system. These include: Transparency, Confidentiality, Efficiency, Sustainability and Integrity. The accreditation system in Rwanda is expected to meet the set standards of the International Society for Quality in Health Care (ISQua), as the system progresses (including training surveyors, setting up an accrediting body /agency and applying ISQua healthcare standards).

3.2. Development of national standards

IHSSP organized and sponsored a one week working session at Musanze district that brought together the MOH team with professional councils, health facilities' staff and other stakeholders to elaborate the Rwanda Essential Hospital Accreditation Standards. These hospital standards were developed and finalized within the same period, thanks to this team.

The standards describe the expected quality in five risk areas of patients care in the hospital. The five risk areas described include:

- Leadership Process and Accountability
- Competent and Capable Workforce
- Environment for Staff and Patients
- Clinical Care of Patients
- Improvement of Quality And Safety

These "Rwanda Hospital Accreditation Standards" have been adapted from the International Essentials of Health Care Quality and Safety designed by Joint Commission International (JCI) an organization that accredits accrediting bodies.

The hospital accreditation standards have been validated by the Accreditation Steering Committee and the Quality Improvement Technical working group (QI/TWG) and inputs incorporated accordingly.

3.3. Quality monitoring and measurement in accreditation system

Within this quarter, IHSSP/MSH supported the MOH to initiate a quality monitoring and measurement mechanism for the accreditation program. In order to be able to identify quality performance gaps and bridge those gaps, the following has been done:

i) Terms of reference have been developed to facilitate the selection of competent health professionals to train as Rwandan accreditation surveyors/assessors with intent of building in-country capacity to manage the program.
ii) The surveyor job description has been developed.
iii) An assessment tool for surveyors and supervisors was developed to guide the assessment of hospitals on the use of the Rwanda Essential Hospital Accreditation Standards and

measure their progress towards meeting standards. The same tool can be used by the hospital quality improvement teams to do their self-assessment.

3.4. Dissemination of Rwanda hospital accreditation standards, additional policies and procedures to the health facilities

In December 2012, IHSSP/MSH supported the dissemination of Rwanda hospital accreditation standards in **27** districts' hospitals. Also, over **270** policies and procedures were disseminated: **each hospital received 10 hard copies** of policies and procedures in addition to the electronic copies that had been sent to each hospital by the Ministry of Health. These had copies were produced and delivered to each hospital to avoid difficulties of failing to access electronically sent documents. This proved to be the right decision as none of the hospitals was found with a printed copy of these policies and documents.

3.5. Challenges/Constraints, Lessons Learned and Next steps

Challenges/Constraints:

- Time allocated to establish the accreditation system in Rwanda is inadequate. There is a need for a longer period of time to be able to assess the impact of using accreditation system to improve quality of healthcare.
- IHSSP Staff (QI Team) workload is very high thus difficult to complete all activities planned. There is a need for additional staff in the QI component.
- Delays in the establishment of the accreditation support structure (the accreditation body and hospital committees). There is a need to have these structures fully functional to enable the preliminary activities start.
- Shortage of Human Resources at MOH. There is a need for a strong quality improvement unit at central level to support implementation of the accreditation program.

Lessons Learned:

- The development of an accreditation system is more complex than expected therefore need for more time and staff.

- It was evident during the development of Rwanda hospital accreditation standards that more policies' procedures and guidelines are needed, including re-alignment of existing ones.
- The candidates for surveyors' training require prior training and experience in quality improvement to have the basic knowledge and understanding of quality improvement terminologies.

Next steps

- Train a team of surveyors to conduct surveys
- Field test of new standards to Rwandan setting
- Develop more survey tools
- Start baseline survey/assessment against the Rwanda Essential Accreditation Hospital Standards in the provincial hospitals
- Continue the dissemination of the accreditation standards to the remaining 15 hospitals
- Develop more policies and procedures identified
- Facilitate the assessed hospitals to develop their accreditation work plans.

IV. CROSS-CUTTING TECHNICAL ASSISTANCE

4.1. Finalize the development of a decentralization strategic plan

Through MOH/decentralization desk, the IHSSP led the process of developing the decentralization strategic plan. A series of meetings and working sessions with line ministries including Ministry of local government (MINALOC), Ministry of Finance and Economic Planning (MINICOFIN), Rwandese Association of Local Government Authorities (RALGA) and the development partners supporting health sector in Rwanda were held, ideas put together and the document developed.

The document was then reviewed and edited by the technical working groups and the line ministries to ensure completeness of the document. These made their edits and inputs and the document has been submitted to the Ministry of Health for final approval.

4.2. Analysis of the Ministry of Health policies and strategic plans against Health Sector Strategic Plan (HSSP III)

The Ministry of Health requested technical support from IHSSP to review all the MoH policies and strategic plans in comparison with the Health Sector Strategic Plan III (HSSP III). The aim of this exercise was to assess:

- To what extent do all health sub-sector policies and strategic plans meet basic National and International standards;
- To what extent do all health sub-sector policies and strategic plans align with HSSP III by strategic interventions;
- To find out if there are strategic plans that are outdated or never validated, and identification of some areas that requires additional policies or strategic plans.

This exercise was completed and a detailed report written with impressive findings and recommendations and has been shared with the Ministry of Health for actions.

4.3. Final drafting of the Health Sector Strategic Plan III

During the quarter, the MOH requested the technical support from IHSSP to produce the final draft of the HSSP III document. MSH recruited a consultant to work with the MOH and IHSSP technical staff in the review of the document. It was reviewed, updated and presented to the technical team of MOH and stakeholders for final comments and recommendations. The document was appreciated with minor editorial comments. IHSSP also used another consultant for proof reading, editing and formatting of this document, and the final product was given to the MOH in December 2012.

4.4. RBC situation and functional analysis

The Rwanda Biomedical Center (RBC) was created in 2011 by the government to support the Ministry of Health. During the last quarter, RBC requested the technical support from IHSSP for a functional analysis of the whole institution to determine how this government institution can be able to draw from the recommendations made by the evaluators the best way to move forward in

managing, re-organizing and improving services provided by RBC to the Rwandan population and other stakeholders. The IHSSP recruited International consultants during the quarter to carry out an extensive situation and functional analysis of RBC.

The team of consultants supported by the local IHSSP and SIAPS staff carried out this assignment for a period of six weeks. The final report with extensive recommendations has been finished and given to RBC for guidance and strategic planning and decision making process.

4.5. Development of IHSSP 2012/13 Work Plan

As the FY 2012/13 was starting, IHSSP teams worked on the development of the annual work plan. The internal project consultations and external consultations with USAID were held to finalize and agree on the Plan. The later was approved by USAID, and implementation of the 1st quarter activity started based on the approved work plan.

4.6. Challenges/Constraints, Lessons Learned and Next steps/plans

Challenges/Constraints

- The MOH has a constraint of human resource. This affects the finalization of the documents or reports developed that are guided by the MOH team;
- Lack of clear directives especially clear terms of reference for the assignment to the consultants;
- Most TWG members hardly provide feedback or comments to the circulated documents;
- Frequent meetings planned with MoH but not attended by principals.

Lessons Learned

- It is cost effective to develop working documents like strategic plans, policies and standard operating procedures for health systems through technical working groups.

Next steps/plans

IHSSP will provide technical support to MOH in the implementation of the decentralization strategic plan. Five District Health Management Teams will be trained in their roles and responsibilities in managing health services at the decentralized level.